

Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received 1/17/12  
Amount 2505.00

I. IDENTIFICATION

#035790

Name Baptist Convalescent Center  
Address 120 Main Street  
City/County/Zip Newport, Ky 41071  
Telephone number 859-581-1938  
Administrator Donna Frodge  
Date facility operation began at current address 1952  
Date facility began operation under current owner 1952

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>167</u>	
Nursing Home		
Nursing Facility		
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

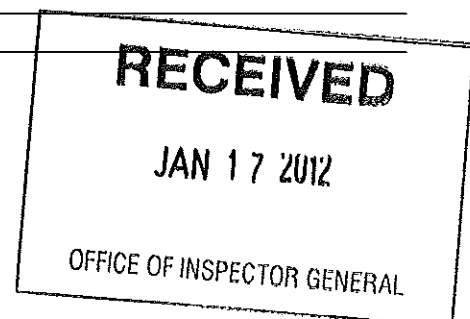
State	Profit	Individual
County	<u>Nonprofit</u>	Partnership
City		Corporation
Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Baptist Life Communities  
1452 Donaldson Highway  
Erlanger, Ky 41018

(OVER)



1/51  
J

If facility owned or leased by a corporation, complete the following:

Name of corporation Baptist Convalescent Center, Inc.  
Address of corporation 1452 Donaldson Highway, Erlanger, Ky 41018  
President or Chairman Dr. Robert Long - CEO  
Vice President Robert Kester - CFO  
Secretary \_\_\_\_\_  
Treasurer \_\_\_\_\_

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

<u>Donna Frodge, LNA</u>	<u>Administrator</u>	<u>1-9-12</u>
Signature of authorized representative	Title	Date

Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)